COLLEGE OF FOOT HEALTH MEDICAL HISTORY FORM

In order to carry out a complete assessment, we require you to complete the following form. Any medical information may be relevant and influence the proposed management of your feet and as such a number of questions are asked about the whole of the body (including medications).

ACCESS TO YOUR RECORDS

You have the right of access to the data that we hold about you and to receive a copy. Formal applications for access must be in writing.

IF YOU DO NOT AGREE

If you do not wish personal data that we hold about you to be disclosed or used in the way that is described in this Code of Practice, please discuss the matter with the Podiatry tutor. You have the right to object; however, this may affect our ability to provide you with foot care. You have a right to withdraw your consent at any time.

SECURITY OF INFORMATION

Personal data about you is stored securely. Medical information can only be accessed by the treating FHP Student or Podiatrist.

WHY DO WE HOLD INFORMATION ABOUT YOU?

We need to keep comprehensive and accurate personal data about patients to provide you with safe and appropriate foot care. We will ask you annually to update your medical history and contact details.

WHAT PERSONAL DATA DO WE HOLD?

To provide patients with a high standard of foot care and attention, we need to hold the following personal information including:

- Past and present medical conditions and medications; personal details such as age, address, telephone number and general medical practitioner
- Clinical photographs and videos (these are stored on your patient records and used for clinical purposes only)
- Information about treatment provided
- Notes of conversations or incidents that might occur for which a record needs to be kept
- Records of consent to treatment
- Correspondence with health care professionals relating to patients.

PERSONAL DETAILS

TITLE ..... FORENAME(S) .....

SURNAME ..... DATE OF BIRTH .....

ADDRESS .....

OCCUPATION .....

HOME ☎ ..... MOBILE .....

WORK ..... EMAIL .....

NEXT OF KIN

NAME ..... RELATIONSHIP TO YOU .....

TELEPHONE .....

GP CONTACT INFORMATION

NAME OF YOUR GP .....

SURGERY ADDRESS .....

.....

SURGERY TELEPHONE .....

MEDICAL HISTORY

Do you have or have you had any of the below? If so, please give further details in the space provided at the end of this section.

- ☐ Type 1 Diabetes. Year diagnosed _____
- ☐ Type 2 Diabetes. Year diagnosed _____
- ☐ Endocrine Disorder or Condition
- ☐ History of leg/foot ulcers
- ☐ Numbness in feet
- ☐ Epilepsy
- ☐ Cancer
- ☐ Heart disease/ angina/ heart attack
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Blood clot/ varicose veins
- ☐ Stroke or TIA
- ☐ Low blood pressure
- ☐ Blood disorders
- ☐ HIV/AIDS/ Hepatitis B/ Hepatitis C
- ☐ Peripheral Vascular Disease
- ☐ Abnormal bleeding after surgery
- ☐ Delayed healing/sepsis
- ☐ Previous nail/foot surgery
- ☐ MRSA
- ☐ Other illness/ operations
- ☐ History of fainting conditions
- ☐ Hepatitis/jaundice/renal disease
- ☐ Neurological condition
- ☐ Memory problems
- ☐ Skin conditions e.g. eczema, psoriasis
- ☐ Musculoskeletal problems
- ☐ Fractures
- ☐ Joint Replacements
- ☐ Any falls in the last 6 months
- ☐ Osteoarthritis
- ☐ Inflammatory arthritis e.g. rheumatoid, psoriatic, SLE
- ☐ Rheumatic fever
- ☐ Back ache/ disc problems
- ☐ Stomach ulcer/ dyspepsia
- ☐ Do you have a carer?
- ☐ Respiratory problems
- ☐ Do you smoke? No. per day _____
- ☐ Have you ever smoked? No. per day _____
- ☐ Blood disorders
- ☐ Mental Health Diagnosis
- ☐ Spectrum Condition
- ☐ Genetic Condition
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Do you drink alcohol? Units per week _____
- ☐ Attending any Specialist clinics
- ☐ Previous foot Care
- ☐ **Allergies/Sensitivities**_____
- ☐ Currently pregnant
- ☐ Any other medical conditions

Further Details:

MEDICAL HISTORY

Please list any sports/ activities in which you participate, at what level (professional/elite, amateur, hobby) and how frequently? (times per week/month/year)

Does your occupation involve periods of standing or walking?

Please list all medications taken (please include any herbal, complementary medication, vitamins, supplements and over the counter medicines or preparations).
PLEASE INCLUDE DOSE AND FREQUENCY

Please describe your current problem/ complaint:

Shoe Size:

Marketing - please could you let us know how you heard about us?:

End Of Form